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14. ABSTRACT **Mental health disorders are the most significant source of medical and occupational morbidity among active duty military members[1] and multiple deployments increase the risk of developing a disorder. Stigma and fear of negative career impact are major reasons attributed to military members not seeking timely mental health services. To date, over one million Active and Reserve military troops have been deployed in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), of whom nearly half have been deployed more than once.[2] There is no indication that the current Global War on Terror (GWOT) will end soon, thus ensuring these numbers will rise. The reality of service members delaying or refusing to seek mental health treatment combined with the large numbers of members with multiple deployments greatly increases the risk that the psychological resiliency and effectiveness of our nation's fighting force is, or will soon be, significantly eroded. Operational Commanders have a responsibility and a unique opportunity to address these issues. This paper addresses three types of stigma (public, self and structural) and the significant role that the stigma related to mental health care has on the psychological resiliency and combat capability of our fighting forces, presents a selected review of related literature, and provides courses of action for the Operational Commander to consider when addressing these issues.**

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STIGMA: "WHAT IS IT AND WHY DOES THE OPERATIONAL COMMANDER NEED TO BE CONCERNED?"

by

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A paper submitted to the Faculty of the Naval War College in partial satisfaction of the requirements of the Department of Joint Military Operations.

The contents of this paper reflect my own personal views and are not necessarily endorsed by the Naval War College or the Department of the Navy.

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06 November 2007

Abstract

Stigma: "What Is It and Why Does the Operational Commander Need To Be Concerned?"

Mental health disorders are the most significant source of medical and occupational morbidity among active duty military members[3] and multiple deployments increase the risk of developing a disorder. Stigma and fear of negative career impact are major reasons attributed to military members not seeking timely mental health services. To date, over one million Active and Reserve military troops have been deployed in Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF), of whom nearly half have been deployed more than once.[4] There is no indication that the current Global War on Terror (GWOT) will end soon, thus ensuring these numbers will rise. The reality of service members delaying or refusing to seek mental health treatment combined with the large numbers of members with multiple deployments greatly increases the risk that the psychological resiliency and effectiveness of our nation's fighting force is, or will soon be, significantly eroded. Operational Commanders have a responsibility and a unique opportunity to address these issues. This paper addresses three types of stigma (public, self and structural) and the significant role that the stigma related to mental health care has on the psychological resiliency and combat capability of our fighting forces, presents a selected review of related literature, and provides courses of action for the Operational Commander to consider when addressing these issues.

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INTRODUCTION

The preservation of a soldier's health should be [the commander's] first and greatest care.

-George Washington

Stigma – from the Greek word "stig" meaning 'to prick'. Ancient Greeks would "prick" the skin of their slaves with sharp instruments to proclaim to all that they were someone's property and unfit for full citizenship.[5] Today, a stigma is a mark of social disapproval or disgrace.[6,7] Many who are stigmatized are viewed as frail, inferior, unstable or morally weak. Mental health disorders are the most significant source of medical and occupational morbidity among active duty military members.[8] Mental illness in western society is highly stigmatized. Stigma, as a barrier to seeking mental health services, is costly not only in that many disorders are much more resistant to treatment in the later stages but, in my twenty years of military nursing experience I have observed many military members are either opting not to stay in the service because of their symptoms or are so disabled that they require a medical evaluation board and are subsequently separated or retired.

Multiple deployments increase the risk of developing a mental health disorder; the Mental Health Advisory Team (MHAT) reports indicate that multiple deployers were significantly more likely to report symptoms consistent with depression, anxiety, acute stress, concerns about deployment length, and also significantly lower personal morale than first-time deployers.[9] To date, over one million service members in the Active and Reserve Components of the U.S. military have been deployed in Operation ENDURING FREEDOM (OEF) in Afghanistan and Operation IRAQI FREEDOM (OIF), of whom nearly half have been deployed more than once.[10] There is no indication that the current Global War on Terror (GWOT) will end soon, thus ensuring these numbers will rise.

Heber, et al (2006) reported that recent research has shown that the fear of stigma is one of the principle reasons preventing soldiers from seeking treatment, even when they realize they have mental health issues. They also note that the literature reports early intervention is a key factor in decreasing the sequelae of many mental health disorders.[11] The reality of service members delaying or refusing to seek mental health treatment, combined with the large numbers of members with multiple deployments, greatly increases the risk that the psychological resiliency and effectiveness of our nation's fighting force is, or will soon be, significantly eroded. Operational Commanders have a responsibility and a unique opportunity to address these issues. This paper will address three types of stigma (public, self and structural) and the significant role that the stigma related to mental health care has on the psychological resiliency and combat capability of our fighting forces, present a selected review of related literature, and provide courses of action for the Operational Commander to consider when addressing these issues.

BACKGROUND

A common thread for all military missions is that individual actions and decisions have to often be made in times of life-threatening or life-altering consequences in an environment full of danger, risk, uncertainty, and stress.[12] Recent empirical research notes that the stresses found in military contexts can reduce operational effectiveness.[13] Further, the implications of mental health disorders affecting the fighting capability of service members has been documented throughout antiquity. "Soldier's heart", "nostalgia", "shell shock", "battle fatigue", "combat stress", "post-traumatic stress disorder" (PTSD) are a few of the more recognizable terms that can be found in the literature. The mostly negative

views of military leadership relating to the care and treatment of service members with mental health disorders have also been apparent over time. In 1915, the British Army in France was instructed as follows:

> Shell-shock and shell concussion cases should have the letter 'W' prefixed to the report of the casualty, if it were due to the enemy; in that case the patient would be entitled to rank as 'wounded' and to wear on his arm a 'wounded stripe'. If, however, the man's breakdown did not follow a shell explosion, it was not thought to be 'due to the enemy', and he was to [be] labeled 'Shell-shock' or 'S' (for sickness) and was not entitled to a wound stripe or a pension.[14]

After World War II, Hollywood immortalized the "slapping incident" in August 1943 that nearly ended General George S. Patton's career. While visiting hospitals and commending wounded soldiers, he slapped and verbally abused two soldiers who were without visible wounds as he determined they were exhibiting cowardly behavior. Thus it is not difficult to discern why many reports recently have confirmed that a majority of military personnel believe that admitting to having a mental health problem or seeking mental health treatment will be detrimental to their career.[15] Stigma is often cited as a major factor contributing to these beliefs.

DISCUSSION / ANALYSIS

Prevention of stress casualties and control of combat and operational stress is a command and leadership responsibility.

-Joint Pub 4-02

Westphal (2004) noted that there are very few studies of the military population that describe the occupational effects of stigma, but there is some knowledge from the corporate workplace that can provide some insight for the military. Significant differences however include the unique entry and retention requirements of the military as compared to the civilian workforce that tend to exclude those with mental disorders. He also noted that

military group norms and regulations have a low tolerance for deviance and reinforce behavioral exceptions with punitive sanctions.[16]

The Department of Defense Task Force on Mental Health (TFMH) notes that stigma often prevents members from seeking care and:

> Stigma also interferes with access to care (because individuals refuse to seek treatment), quality of care (because individuals seek care 'off the books'), and continuity of care (because individuals may not inform military medical personnel about prior mental health treatment)…..Further, stigma is of particular concern in the military because the degree to which military members may bear responsibility for lives beyond their own.[17]

The Mental Health Advisory Team has conducted four surveys of personnel deployed to Afghanistan and Iraq. MHAT-IV reports that 59 percent of Soldiers and 48 percent of Marines surveyed believed they would be treated differently by leadership if they sought mental health care.[18] Even more concerning are recent findings that service members who screened positive for mental health illness symptoms were twice as likely to cite concerns about stigma as those without symptoms.[19] To understand stigma in the military it is important to comprehend the belief about career harm. As Westphal (2004) notes, authority over a service member's career resides with the commanding officer. Perceptions (valid or not) that one will be viewed differently or looked down upon by one's leaders play a critical role in determining whether a service member will seek needed care and treatment.

Stigma

The DoD TFMH reports that Sammons (2005) noted three unique manifestations of stigma each requiring multiple, targeted intervention strategies: 1) Public Stigma – public (mis)perceptions of individuals with mental illnesses; 2) Self-Stigma – an individuals' perception of themselves; and 3) Structural Stigma – institutional policies or practices that unnecessarily restrict opportunities because of psychological health issues.[20]

Addressing Public Stigma: The Task Force recommendations include providing factual information about mental illness in the form of an anti-stigma education campaign using evidence-based techniques. The focus should be that combat can wound the mind just as one can sustain bodily injury. Assertive, early intervention to service members and their families are keys to health and force readiness.[21]

Addressing Self-Stigma: It is noted that recognition of a problem, the need for change, and easy access to help are necessary elements for the individual service member to over come self-stigma. The Task Force recommends embedding uniformed providers in military units in addition to factual education as possible solutions. System delays, bureaucratic roadblocks and policy inconsistencies must also be overcome, otherwise all efforts to address stigma are meaningless.[22]

Addressing Structural Stigma: The Task Force appreciates the need to balance the interests of the individual with those of DoD and the chain of command to maintain mission readiness. Reporting:

> ….current thresholds for command and security notifications are overly conservative and contribute to structural stigma. Concerns that self-identification will impede career advancement or effort to obtain a security clearance may lead service members to avoid needed care, even at early stages when problems are most remediable. The net result is that service members delay or avoid seeking services, and continue operational roles while their problems remain unidentified and untreated and become more severe.[23]

The Task Force specifically addresses the legitimate need for operational commanders to maintain discipline and to be fully informed regarding the mission readiness of the service members assigned to them; noting that if a member cannot function he may need to be separated from the military.[24] The report further notes that this must be balanced with the responsibility to restore to a full level of function those damaged in the line of duty.

Pressure from leaders and peers to accept an administrative discharge so that they could be replaced with a fully functioning member were often reported by service members with mental health issues:

> The Department of Defense should carefully assess history of occupational exposure to conditions potentially resulting in post-traumatic stress disorder, traumatic brain injury, or related diagnoses in service members facing administrative or medical discharge. While such conditions are not exculpatory of misconduct, the need for treatment in members with a history of occupational exposure should be considered.[25]

Resiliency

Military training and indoctrination are methods used to establish the necessary discipline and mission readiness that operational commanders are concerned about. In addition to skill acquisition and technical proficiency, this training and indoctrination teaches service members to develop an inner strength to face adversity, fear, and hardship during combat with confidence and resolution – in essence, to develop *psychological resiliency*.[26] Webster defines 'resilience' as "an ability to recover from or adjust easily to misfortune or change."

Psychological fitness is the term used by Cawkill & Ader (2006) and defined as "The mental readiness to confront the challenges of deployment, whether combat, humanitarian, peacekeeping, or combination of all three. [It] is the mental hardiness, resilience and mental toughness to face rigors of missions ranging from boredom to threat."[27] They note that military leaders affect the psychological fitness of their units by ensuring appropriate training and sustaining motivation and morale. Authors use a variety of terms – psychological fitness, mental readiness, psychological resiliency – all with the intent of conveying this

concept of developing a protective, inner strength. If successful, operational readiness is enhanced and combat stress reactions and symptoms may be lessoned or avoided.

Factor Force

The impetus for developing psychological resiliency is to protect the individual members of our fighting force. Vego (2000) notes that this Operational Factor of 'Force' is critical in the accomplishment of military objectives at all levels of war[28] and that the associated manifestations of the human element are the most important.[29] These human manifestations include: morale and discipline, small-unit cohesion, combat motivation, leadership, doctrine, and training.[30] The classical military theorist, Von Clausewitz, also refers to the decisive influence that human moral factors have on the elements of war.[31] All of these human elements may be affected by the psychological resilience of the members.

Factor Force-Time

Individuals with lower levels of psychological resilience may be more prone to mental health symptom development. The stigma associated with seeking mental health care or treatment may mean that service members with symptoms deny their severity or delay seeking treatment due to a fear of ridicule or career safety. This delay (Factor Time) may mean that Factor Force is reduced in overall effectiveness because for many mental health disorders, the longer one waits to seek treatment the more severe the symptoms become. The more severe the symptoms, the more likely consequence the service member will be hospitalized or evacuated out of theater. Thus, fighting capability (Factor Force) is reduced. One way to effectively manage the Factors of Force-Time is for leaders to take a pro-active approach in addressing the stigma associated with mental health care.

Operational Leadership

> *The principle requirements for a successful operational leader are high intellect, strong personality, courage, boldness, and will to act, combined with extensive professional knowledge and experience; creativeness and innovation are not only desirable, but necessary*.
>
> -Milan Vego

Military leaders are in positions of authority over subordinates' careers; their perceptions of mental illness are potential sources of organizational norms regarding mental health service use.[32] A lack of knowledge to make consistently sound mental health-related judgments was almost unanimously identified by Navy surface warfare leaders in a study by Westphal (2004).[33] These leaders were forced to display unusual creativity and innovation, often in times of crisis, to mange the mental health issues of their subordinates in an organization (i.e., DoD) that is less than consistent and efficient in its program and policy guidance. He identified a need for a systematic review of resources, program goals and referral procedures, along with clarifying policy ambiguity, facilitating partnerships between fleet leaders and mental health providers, and improved leadership training.[34] These measures, if implemented would potentially address the professional knowledge and experience that is necessary, but currently gapped, for the operational leader.

Leadership Issues

One of four goals identified by the DoD TFMH was "At all levels, visible and empowered leaders will advocate, monitor, plan, coordinate and integrate prevention, early intervention, and treatment."[35] A leader brings his pre-conceived notions and values with him as he promotes through the ranks. One negative, personal or professional encounter with mental health may color his current thoughts/actions regarding his subordinate's access to, or need for, mental health care or treatment.

Despite a large volume of evidence that confirms service members fear the stigma associated with seeking mental health care, in a study of attitudes that Navy surface warfare leaders have regarding mental illness and the use of mental health services, Westphal (2004) found that mental illness stigma was not a dominant influence of leaders' attitudes about mental illness and subordinates use of mental health services. The leaders indicated organizational barriers and differences between line commanders and mental health providers as being more important than stigma.[36] This disparity in service members' views vs. leaders' views may in itself foster stigma and be a barrier to care and treatment.

Selected Literature Review

Several recent reports have outlined various ways leaders might approach addressing the mental well-being (psychological resiliency) of their troops, organizational barriers, and/or stigma associated with seeking mental health services. In summation:

The United States Marine Corps began their Operational Stress Control and Readiness (OSCAR) program in 1999.[37] This program features embedding mental health providers directly in operational units at the regiment level, versus attaching them to external medical or combat stress teams. The providers train, deploy, and redeploy with the unit building trust and ensuring continuity of care. An additional unique feature of this program is the full-time assignment of non-commissioned Marine Corps officers (E6 and above) to the OSCAR teams. These NCOs are seasoned war-fighters who have credibility in the eyes of the troops and who help bridge the gap between mental health and military operations. The goals of the program are prevention, early identification, and effective treatment of mental health related issues at the lowest level possible.[38]

The Canadian military has established Operational Trauma and Stress Support Centers (OTSSC's) for their military members returning from overseas deployments with deployment related psychological symptoms.[39] Combined with Operational Stress Injury (OSI) clinics run by the Veterans Affairs Canada, they have collaborated to meet the needs of service members and their families and reduce the stigma associated with seeking mental health care. A unique feature of this program is the use of a national peer support program made up of other military members and veterans who have themselves suffered from deployment related mental health conditions. These members receive special training to provide support and counseling to their fellow service members when a job (combat) related traumatic event occurs. They are a "peer" because they share or have experienced similar conditions or they have suffered with comparable symptoms; additionally, they have credibility with the chain of command because they are seasoned veterans. A major focus, in addition to supporting individual service members, is educating leaders and the military chain of command on operational stress injuries, leadership responsibilities and awareness of departmental policies pertaining to OSI's. The goals of the programs are enhanced structured social support for recovery from operationally-related mental health problems and reduction in stigma.[40]

Castro, Hoge & Cox (2006) believe that the solution to ensuring that soldiers receive the help they need lies in a multi-level strategy involving both the soldier and leaders. They developed a series of "Battlemind Training"[41] modules aimed at minimizing the risks associated with combat and building psychological resiliency. The training builds on soldier strengths using the components of self-confidence and mental toughness – two strengths that all soldiers must have to perform in combat. The training highlights the roles that both

soldiers and leaders must do to fight the myths (stigma) of mental health that prevent those that need help from seeking it.[42]

Yantsislav, et al, (2006) have identified a need for pre-deployment training and psychological support during and after deployment for the Bulgarian military, stating: "In our opinion, the stress prevention and control training should be incorporated as an implicit part in the everyday training and education of Peace Support Operations (PSO) participants."[43] A major focus is leadership training to include recognition of stress and stress-related behaviors, unit cohesion, social competence (how to interact with civilian agencies, multinational hosts, the local population, etc.) and building a family support network.[44]

Major General Cammaert, Royal Netherlands Marine Corps, has commanded six PSOs around the world. He notes that commanders at all levels should recognize that they are responsible for, and have a critical role in the education and management of stress and mental health issues of their troops. "Pre-deployment training, knowing your soldiers and the management of stress during and after operational deployments are fundamental to helping soldiers deal with adjusting their reactions to normal circumstances after having been under abnormal conditions."[45] This is done by keeping stress victims in or close to their units, solving problems at the earliest stage possible (diagnose early before symptoms escalate), and emphasizing that "it is OK to seek help."[46]

Thompson & McCreary (2006) noted that many militaries provide stress management briefings, but that the effectiveness of this approach is questionable because 1) they are usually conducted from an academic framework and given by mental health professionals who do not possess operational credibility with the service members; 2) there is rarely practical training associated with the content; and 3) the stigma associated with mental health

issues contributes toward a general resistance to, and/or denial of, the relevance of the training.[47] They suggest a "mental readiness" training program that is delivered by trainers with technical and operational credibility (mental health professionals serve as consultants for course content) that integrates stress management into the context of more intense, operationally relevant training situations. The goal is for these skills to become reflexive in the same way that technical proficiency becomes reflexive in the operational setting. Mental readiness is viewed as a skill that can be acquired and developed much like physical fitness, potentially providing a higher baseline resiliency level for military members that could reduce the impact of chronic operational stress.[48]

Cawkill & Adler (2006) identified a need for more specific leadership training relating to psychological fitness in their report of *The Military Leaders Survey: NATO Military Leaders' Perspectives on Psychological Support in Operations* at the pre-deployment, deployment and post-deployment stages of operations. A majority of the 172 leaders from 16 NATO nations reported that unit leaders are often the first to respond or deal with mental health issues and that realistic training, using case scenarios and best-practices for specific situations would be beneficial.[49]

Castro, et al, (2006) identified actions that leaders can take to build resiliency in their soldiers that enable them to lead subordinates successfully through the rigors of combat. A flexible, pragmatic leadership style encourages the sharing of common objectives, promotes trust and fairness, ensures credibility, maintains subordinate initiative, builds teamwork and can dramatically influence unit effectiveness.[50]

CONCLUSIONS

Mental health disorders are a significant source of medical and occupational morbidity among all branches of the military. Multiple deployments increase the risk of developing a mental health disorder. The stigma associated with seeking mental health services is pervasive, both in the U.S. and abroad. This stigma prevents many who need mental health services from seeking help and inadvertently, may affect the way leaders approach not only the mental health provider, but the training and use of services for his troops.

Operational leaders hold the responsibility for their subordinates' well being, before, during and after deployment. Military leaders affect the psychological fitness/resiliency of their units by ensuring appropriate training and sustaining motivation and morale. Leaders' (both at the senior levels but particularly at the mid-level) attitudes regarding mental health and the use of mental health services dramatically affects the perceptions of their subordinates (i.e., The Commander may be very supportive but if the Corporal does not understand, the Private is not going to get the help he may need.).

There is an identified need for improved pre-deployment training; both for service members and particularly for leadership. Psychological resilience needs to be viewed as an acquirable skill that can be attained just as physical fitness can be attained. Stress management training is a portion of this skill and needs to be incorporated into regular operational training so that it becomes routine and is not viewed as an academic exercise. Seasoned veterans, who have already established credibility with the troops, should deliver this training with mental health professionals serving as consultants.

Organizational barriers may complicate the process for a member who may need services, frustrate the Commander who is trying to take care of his troops while actively engaged in a mission, and can potentially overwhelm the mental health provider. An example is the administratively-heavy, complicated DoD mental health policies and regulations that vary from service to service. Many commanders are not familiar with their service-specific regulations and look to the mental health provider for guidance. The mental health provider in the operational environment often treats members from several services, necessitating at least a marginal knowledge of the various regulations of each of the services. This becomes even more complicated if multi-national members are treated. These barriers foster structural stigma[51] and must be addressed at the service component level to be effectively resolved.

Some may argue that current predeployment training requirements are already so demanding that there is not any time for psychological resiliency training or that in the bigger scheme of planning and executing combat operations, the stigma associated with mental health is not an important issue. While it is true that reducing the stigma associated with mental health care and enhancing the psychological resiliency of the troops presents many challenges, recent reports consistently identify the potentially negative impact to the combat capability of the fighting force if these are not addressed. An Operational Commander would not go into combat without ensuring the technical proficiency and physical readiness of his unit; he can not afford to take his troops into battle without having done everything in his power to ensure that they are psychologically prepared and know that the Commander is supportive should they require mental health services in the future.

RECOMMENDATIONS

It takes courage for a Soldier to ask for help, and it takes Leadership to help a fellow Soldier get help.
-Battlemind Training
Castro, Hoge & Cox (2006)

Addressing the mental health needs of our nation's military members and their families is a formidable task that must begin at the national and strategic level with policy/regulation and legislative funding change among others. These are outside the scope of this paper, and despite the magnitude of these issues, there are courses of action the Operational Commander can take to address stigma and improve the psychological resiliency of his troops that may result in enhanced combat capability both now and in the future.

The Commander should start with an analysis of himself. What are his thoughts/ feelings regarding mental health? Have past experiences with either mental health providers or service members displaying mental health symptoms been positive or negative? Has there been an incident with a bad outcome? These and other reflective questions will help ensure that personal biases are not inadvertently conveyed to his Staff or the troops. His guidance regarding stigma and psychological resiliency training then needs to be passed in his 'Commander's Intent'. This puts mental health needs on par with other operational tasks.

The Commander should review the training calendar to ensure there is adequate time allowed for psychological resiliency training, especially if the unit will be deploying soon. Particular attention should be paid to the number of deployments for the unit/troops as those with multiple deployments are at increased risk of developing mental health symptoms. Psychological resiliency training is more than the typical Stress Management and Suicide Awareness briefs that are often included in current training schedules. Psychological readiness training should be on par with physical readiness or technical proficiency training

and incorporated into routine operational training at every possible opportunity. The Commander may want to consider additional training for NCOs and officers so that all leaders in the chain of command understand and support his Commander's Intent.

The Commander should discuss the training objectives and Commander's Intent with a mental health professional. If one is not organic to the unit, he may want to consider a Request for Forces (RFF). If at all possible the mental health professionals should be imbedded within the unit. These professionals need to train with the unit to fully appreciate the operational demands placed on the troops and to develop rapport with them. The troops, and especially the junior leaders, need to develop trust and feel confident that they can approach the mental health providers when they have an issue or are concerned about a service member.

Although this option may initially be considered not cost-effective, the Commander should consider reassigning seasoned, combat veterans to the psychological resiliency training team. They have established credibility with the troops and can provide realistic examples of combat related issues that are likely to be encountered, offering solutions that promote psychological well being and minimize the risk of developing mental health symptoms. If reassigning troops is not an option, an alternative may be to consider having volunteers, current service members or veterans, who have suffered with deployment-related mental health issues assist with the training.

The courses of action presented here are not radical changes to current operations. They are subtle modifications that, like other positive leadership qualities, if effectively implemented can provide the Commander with huge payoffs in troop morale and

performance. These recommendations are not prescriptive; they can be tailored to meet the particular needs of a unit or the personality of the Commander.

In the last several years many Operational Commanders have found themselves having to modify the more traditional methods of waging war to meet current threats. These changes did not happen over night. They developed over time as experience was gained and lessons were learned from successful engagements. Addressing the psychological resiliency and stigma associated with mental health care should be viewed as another of these lessons. The immediate future holds a high probability of continued troop involvement across the range of military operations. The Operational Commander cannot afford the erosion of the combat capability of our fighting force if these issues are left unchecked.

NOTES

(All notes appear in shortened form. For full details, see the appropriate entry in the bibliography.)

[1] Westphal, *Discourse Analysis*, 1.
[2] DoD TFMH, *An Achievable Vision*, 5.
[3] Westphal, *Discourse Analysis*, 1.
[4] DoD TFMH, *An Achievable Vision*, 5.
[5] Stuart, *Stigma and Work.*
[6] Goffman, *Stigma: Notes on the Management of Spoiled Identity.*
[7] Dovidio, Major, & Crocker, *Stigma: Introduction and Overview*.
[8] Westphal, *Discourse Analysis*, 1.
[9] OMNF-I & OTSG, *MHAT-IV*.
[10] DoD TFMH, *An Achievable Vision*, 5.
[11] Heber, et al, *Combining Clinical Treatment and Peer Support*, 23-1.
[12] Orasanu & Backer, *Stress and Human Performance*, 72-107.
[13] Thompson & McCreary, *Enhancing Mental Readiness*, 4-2.
[14] Shephard, *A War of Nerves.*
[15] Westphal, *Discourse Analysis;* Heber, et al, *Combining Clinical Treatment and Peer Support;* Nash, *Operational Stress Control and Readiness (OSCAR);* Thompson & McCreary, *Enhancing Mental Readiness.*
[16] Thompson & McCreary, *Enhancing Mental Readiness.*
[17] DoD TFMH, *An Achievable Vision*, 15.
[18] OMNF-I & OTSG, *MHAT-IV*.
[19] Hoge, et al, *Combat Duty in Iraq and Afghanistan*, 13-52.
[20] Sammons, *Psychology in the Public Sector*, 899-909.
[21] DoD TFMH, *An Achievable Vision*, 15-16.
[22] Ibid., 16.
[23] Ibid., 20.
[24] Ibid., 21.
[25] Ibid., 22.
[26] Castro, Hoge & Cox, *Battlemind Training*, 42-2.
[27] Cawkill & Adler, *Military Leaders Perspectives*, 11A-2.
[28] Vego, *Operational Warfare*, 59.
[29] Ibid., 68.
[30] Ibid., 73.
[31] Clausewitz, *On War*, 184.
[32] Westphal, *Discourse Analysis*, 1.
[33] Ibid., 25.
[34] Ibid.
[35] DoD TFMH, *An Achievable Vision*, ES-2.
[36] Westphal, *Discourse Analysis*, 1.
[37] Nash, *Operational Stress Control and Readiness (OSCAR),* 25-6.
[38] Ibid.
[39] Heber, et al, *Combining Clinical Treatment and Peer Support*, 23-2.
[40] Ibid.
[41] Castro, Hoge & Cox, *Battlemind Training*, 42-2.
[42] Ibid.
[43] Yanakiev, et al, *Psychological Dimensions*, 16-1.
[44] Ibid.
[45] Cammaert, *Stress and Psychological Support,* KN1-6.
[46] Ibid.
[47] Thompson & McCreary, *Enhancing Mental Readiness*, 4-1.
[48] Ibid.
[49] Cawkill & Adler, *Military Leaders Perspectives*, 11A-1.

[50] Castro, et al, *Leader Actions*, 1.
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